SCHOOL AGE BACKGROUND INFORMATION SHEET

Please fill in as much of this form as you can. Not all areas will be relevant. The more information you give us, the better we can do our assessment. Every reference to 'child' is taken to mean 'child or young person'.

We need to know about your own concerns as well as the concerns of other professionals, which may be different.

We also need to know about your child's strengths and what they are best at, so that we can get a clear picture of the whole child and their situation.

Filling this in before you come gives you time to think and to check out the details.

Thank you for your time and we look forward to meeting you.

Child's Name: M ◯ F ◯ Date of birth: / / Age:

Address:

Postcode: Telephone:

GP: School:

Religion: Languages spoken at home:

Date sheet completed: / / Completed by:

Date of referral: / / Referred by:

Reason for referral:

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Parent's / Carer's / Child's concerns (please write down what worries you, any questions you want to ask in clinic and what you want to get from the assessment):

Nurseries and Schools attended (with dates):

Professionals involved:

Name:	Profession:	Involved since:	Next appointment:

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PAST MEDICAL HISTORY

PREGNANCY AND EARLY HISTORY

Any problems in pregnancy:

Any illnesses:

Bleeding:

Tablets / medication:

Cigarettes / day:

Any problems on any of the scans during pregnancy:

LABOUR

Spontaneous onset ◯ Induced ◯ Full term ◯ If premature, by how many weeks:

Any problems:

DELIVERY

Place of birth:

Normal ◯ Breech ◯ Forceps ◯ Ventouse ◯ Caesarian ◯

Was there any sign that the baby was distressed before birth:

Birth weight:

Did she / he need help with breathing: YES ◯ NO ◯ Did she / he need **Special Care**: YES ◯ NO ◯

Any problems in the newborn period:

How old was the baby when you took her / him home:

EARLY FEEDING AND WEANING

Any feeding problems early on:

If breast fed, until what age:

Solids introduced from age:

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SUBSEQUENT MEDICAL HISTORY

Please write down any **diagnoses** or **conditions** your child has and age of diagnosis:

Hospital visits:

Please write down as much as you remember, including which hospital, which department (eg A&E, outpatients, ward), when and what for:

Other illnesses or accidents:

Measles ◯ Mumps ◯ Chicken pox ◯ German measles ◯ TB ◯ Other:

Any complications:

Immunisations:

Please write down any jabs that you know your child has **NOT** had, which they would usually have had by now, including the reasons:

GENERAL HEALTH

Does your child have:

A regular cough ◯ Asthma ◯ Eczema or other skin problem ◯ Bowel problem ◯

Difficulties passing water ◯ Urine infections ◯ Fits, faints or funny turns ◯ Headaches ◯

Heart problems ◯ Any other medical, dental or mental health problems ◯

Please give details:

When did she / he last see the dentist:

Medication including doses and times given:

Allergies to medication or anything else, including description of any reactions:

FAMILY HISTORY

Birth Mother (name): Date of birth: / /

Health: Occupation:

Birth Father (name): Date of birth: / /

Health: Occupation:

Are birth parents related eg cousins: YES ◯ NO ◯ Are both parents living at home: YES ◯ NO ◯

If **NO**, how often is contact:

Contact address of parent if not on front page:

Details of everyone else living at home:

Name:	Date of birth:	Health:

Any brothers, sisters, of half-brothers or sisters not living at home:

FAMILY HISTORY (continued)

Have you or anyone in the close family had any miscarriages, stillbirths or had a young child who died:

Please write down if anyone in the family (eg parents, sisters, brothers, grandparents, cousins etc) have had health problems in any of the following areas:	
Hearing	
Vision	
Speech	
Learning	
Epilepsy, fits or funny turns	
Muscle problems	
Physical disability	
Mental health problem	

Other health problems (please say what):

Did anyone in the family go to special school or need extra help at school:

HOUSING

Please write down any issues, as we can sometimes help:

Does anyone smoke at home: YES ◯ NO ◯ Any pets: YES ◯ NO ◯

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SUPPORT AND INFORMATION

Where do you get your support from (eg grandparents etc):

Do you get any **special benefits** eg DLA: YES ◯ NO ◯ Do you use **respite care or short breaks**: YES ◯ NO ◯

Does your child have a **social worker**: YES ◯ NO ◯

Do you get the **support you need to care for your child**? If not, please say what support you need:

Do you have **enough information about your child and services available**? if not, please say what you want:

DEVELOPMENTAL HISTORY AND CURRENT FUNCTIONING

Please describe how your child plays, what she / he enjoys and what she / he is like as a person:

Movements and posture:

How does your child move around:	

Please list any equipment required to assist with movements or posture:

At what age did she / he: sit without support:		walk alone:	

Can she / he: run: YES ◯ NO ◯ jump with feet together: YES ◯ NO ◯ climb stairs: YES ◯ NO ◯

kick a ball: YES ◯ NO ◯ pedal a bike: YES ◯ NO ◯

get up easily from sitting on the floor, without using hands: YES ◯ NO ◯

What are her / his **best skills** in the area of movements:

Please write down any worries about movements, posture, balance or coordination:

Personal care and Hand Function:

Which **hand** does she / he use most: RIGHT ◯ LEFT ◯ At what age did she / he first reach to grab at toys:

What is her / his **best skills** in this area:

Please write down any difficulties with personal care skills (feeding, dressing, toileting, washing etc) or hand function:

Feeding:

Can she / he manage a range of textures without problem: YES ◯ NO ◯

Any retching, vomiting or acid brash: YES ◯ NO ◯

What is her / his **best skill** in this area:

Please write down any difficulties with feeding, chewing or swallowing, including details of special diet / feed etc:

Continence:

What is her / his **best skill** in this area?

Please write down any **concerns**:

Hearing:

What is her / his **best skill** in this area:

Please write down any **concerns** and any **tests** your child has had:

Vision:

What is her / his **best skill** in this area:

Please write down any **concerns** and any **tests** your child has had:

Speech, Language and Social Communication:

Age of first smile: ____ Does she / he smile at you to greet you or get your attention: YES ◯ NO ◯

Was she / he a quiet / vocal / noisy baby: YES ◯ NO ◯ Did she / he go through a phase of babbling: YES ◯ NO ◯

Did / does she / he enjoy peekaboo: YES ◯ NO ◯

How does your child communicate (eg speech, signing, gestures, picture exchange etc):

Is she / he able to indicate a clear Yes / No response and how is this done:

If speech is the main means of communication, is this clear for a stranger to understand?: YES ◯ NO ◯

Is there anything unusual about the quality or tone of speech:

Does she / he **point** at things: to ask for them: YES ◯ NO ◯

to share interest with you ('oh look, there's a..): YES ◯ NO ◯

Does she / he bring things to show you to share interest with you (eg toys, books etc): YES ◯ NO ◯

Please describe any **pretend / creative imaginitive play** your child does now:

Did she / he **play with imagintation** as a small child (eg pretend to feed teddy, pretend to make a drink etc):

Speech, Language and Social Communication (continued):

Does she / he **show an interest** in what you are doing or try to copy things you do: YES ◯ NO ◯

Please give examples:

Please describe **how your child plays with other children** & the sort of things they do together:

Does she / he have a special friend: YES ◯ NO ◯ Does she / he enjoy cuddles: YES ◯ NO ◯

When would she / he come for a cuddle:

How does she / he react if you are hurt or upset:

Would she / he show concern or offer a cuddle: YES ◯ NO ◯

How does she / he generally respond to others' emotions?

Please give examples of her / his **best skills in understanding** what you say:

Please give examples of her / his **best skills in speech and communication**:

Please write down any concerns with speech, language or social communication:

Learning:

Is your child learning new things all the time: YES ◯ NO ◯

Are there any things she / he used to be able to do, but can't any more i.e. do you think she / he has **LOST** any developmental skills: YES ◯ NO ◯

Does she / he get **extra help** at school: YES ◯ NO ◯

Please specify what:

Does she / he have an **individual education plan**: YES ◯ NO ◯

Does she/he have a **statement of special educational needs**: YES ◯ NO ◯

What are her / his **best skills overall with learning** (eg remembering routes to places, or things that happened, counting, building, doing puzzles, computer, reading, maths etc):

Please write down any concerns about your child's learning or developmental progress:

Behaviour:

Please give examples of **best behaviour**:

Please describe any **unusual habits or mannerisms**:

Does she / he show any **repetitive or unusual aspects to play** eg lining toys up endlessly, playing with wheels rather than cars, sniffing or feeling things in an unusual way etc:

Behaviour (continued):

How does she / he **react to any changes in routine**:

Does she / he have any **rituals of behaviour** at any time (eg having to do things in a particular order, sit in a particular place etc):

Does she / he show any **unusual sensitivities** eg to household noises, or to particular objects or situations:

Please write down any **concerns about behaviour**:

Sleep

Please describe your child's **sleep pattern and any concerns**:

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Please write here anything else you think it is important for us to know about your child, your family or your circumstances:

THANK YOU VERY MUCH FOR GETTING THIS FAR.
ALL THIS INFORMATION WILL HELP US TO HELP YOUR CHILD.

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PHYSICAL EXAMINATION (The Paediatrician will complete this section)

Height (cm):		percentile:		Weight (kg):		percentile:		OFC:		percentile:	

General appearance, unusual features etc:

Skin (including neurocutaneous stigmata):

ENT:	
CVS:	
Chest:	
Abdomen:	
Genitalia:	
Spine:	
CNS:	

Behaviour, play etc:

Opinion and Plan

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